		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023390

Facility Name: ST ANN'S HEALTHCARE CENTER

Address: 770 STATE STREET (Number) CHESTER (City) 62233 (Zip Code)

County: RANDOLF

Telephone Number: 618-826-2314 **Fax #** 618-826-2316

IDPA ID Number: 37-1023098001

Date of Initial License for Current Owners: 03-01-77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: MIKE GREER **Telephone Number:** 618-826-2314

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01-01-03 to 12-31-03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) DAVID REIS, PRESIDENT
(Firm Name & Address) WDM COMPUTER SERVICES INC., 1900 HARRISON QUINCY, ILL 62301
(Telephone) 217-228-1950 Fax # 217-222-6053

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	32	Skilled (SNF)	32	11,712	1
2		Skilled Pediatric (SNF/PED)			2
3	87	Intermediate (ICF)	87	31,842	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	43,554	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	160	23	2,264	2,447	8
9	SNF/PED					9
10	ICF	17,485	9,255		26,740	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,645	9,278	2,264	29,187	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.01%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 03-01-77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 15 and days of care provided 2,264

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 2003 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	181,049	11,576	5,064	197,689		197,689		197,689			1
2	Food Purchase		140,178		140,178	(4,377)	135,801	(5,098)	130,703			2
3	Housekeeping	71,311	15,999	802	88,112		88,112		88,112			3
4	Laundry	53,438	13,147		66,585		66,585		66,585			4
5	Heat and Other Utilities			102,556	102,556		102,556		102,556			5
6	Maintenance	37,657	13,892	48,420	99,969		99,969	(535)	99,434			6
7	Other (specify):*											7
8	**TOTAL General Services**	343,455	194,792	156,842	695,089	(4,377)	690,712	(5,633)	685,079			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	948,253	78,715	11,570	1,038,538		1,038,538		1,038,538			10
10a	Therapy	51,019		245,292	296,311		296,311		296,311			10a
11	Activities	34,797	14,120	4,178	53,095		53,095		53,095			11
12	Social Services	33,982	2,922	7,188	44,092		44,092		44,092			12
13	Nurse Aide Training											13
14	Program Transportation		2,882		2,882		2,882	(2,882)				14
15	Other (specify):* SALES TAX			1,036	1,036		1,036	(1,036)				15
16	**TOTAL Health Care and Programs**	1,068,051	98,639	269,264	1,435,954		1,435,954	(3,918)	1,432,036			16
	C. General Administration											
17	Administrative	63,076		72,000	135,076		135,076	(28,622)	106,454			17
18	Directors Fees											18
19	Professional Services			20,937	20,937		20,937	1,116	22,053			19
20	Dues, Fees, Subscriptions & Promotions			38,037	38,037		38,037	(24,756)	13,281			20
21	Clerical & General Office Expenses	90,112	18,869	15,246	124,227		124,227	42,929	167,156			21
22	Employee Benefits & Payroll Taxes			196,248	196,248	4,377	200,625	7,012	207,637			22
23	Inservice Training & Education			1,452	1,452		1,452		1,452			23
24	Travel and Seminar			7,774	7,774		7,774	392	8,166			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			91,147	91,147		91,147		91,147			26
27	Other (specify):* BAD DEBTS			1,666	1,666		1,666	(1,666)				27
28	**TOTAL General Administration**	153,188	18,869	444,507	616,564	4,377	620,941	(3,595)	617,346			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,564,694	312,300	870,613	2,747,607		2,747,607	(13,146)	2,734,461			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER #0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			70,502	70,502		70,502	1,966	72,468			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			57,487	57,487		57,487	(871)	56,616			32
33	Real Estate Taxes			30,845	30,845		30,845	(88)	30,757			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			59	59		59	(59)				35
36	Other (specify):* PENALTY			5,000	5,000		5,000	(5,000)				36
37	**TOTAL Ownership**			163,893	163,893		163,893	(4,052)	159,841			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation		2,882		2,882		2,882	(2,882)				38
39	Ancillary Service Centers		126,905		126,905		126,905	(7,736)	119,169			39
40	Barber and Beauty Shops			7,813	7,813		7,813		7,813			40
41	Coffee and Gift Shops		19,302		19,302		19,302	(980)	18,322			41
42	Provider Participation Fee			65,153	65,153		65,153		65,153			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		149,089	72,966	222,055		222,055	(11,598)	210,457			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,564,694	461,389	1,107,472	3,133,555		3,133,555	(28,796)	3,104,759			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,098)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(600)	6		6
7	Sale of Supplies to Non-Patients	(980)	41		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(892)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,036)	15		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(5,764)	14,38		16
17	Non-Care Related Fees	(7,736)	39		17
18	Fines and Penalties	(5,000)	36		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(571)	20		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,666)	27		24
25	Fund Raising, Advertising and Promotional	(24,596)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule PROPERTY TAX	(88)	33		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (54,027)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(315)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 25,231		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (28,796)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

ST ANN'S HEALTHCARE CENTER

ID# 0023390

Report Period Beginning: 01-01-03

Ending: 12-31-03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,098)	0	0	0	0	0	0	0	0	0	0	(5,098)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(600)	0	65	0	0	0	0	0	0	0	0	(535)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,698)	0	65	0	0	0	0	0	0	0	0	(5,633)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(1,036)	0	0	0	0	0	0	0	0	0	0	(1,036)	15
16	**TOTAL Health Care and Programs**	(1,036)	0	0	0	0	0	0	0	0	0	0	(1,036)	16
	C. General Administration													
17	Administrative	0	(3,997)	(24,625)	0	0	0	0	0	0	0	0	(28,622)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	364	752	0	0	0	0	0	0	0	0	1,116	19
20	Fees, Subscriptions & Promotions	(25,167)	0	411	0	0	0	0	0	0	0	0	(24,756)	20
21	Clerical & General Office Expenses	0	32,287	10,642	0	0	0	0	0	0	0	0	42,929	21
22	Employee Benefits & Payroll Taxes	0	5,103	1,909	0	0	0	0	0	0	0	0	7,012	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	392	0	0	0	0	0	0	0	0	392	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(1,666)	0	0	0	0	0	0	0	0	0	0	(1,666)	27
28	**TOTAL General Administration**	(26,833)	33,757	(10,519)	0	0	0	0	0	0	0	0	(3,595)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(33,567)	33,757	(10,454)	0	0	0	0	0	0	0	0	(10,264)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 **Report Period Beginning:** 01-01-03 **Ending:** 12-31-03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	1,966	0	0	0	0	0	0	0	0	0	1,966	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(892)	21	0	0	0	0	0	0	0	0	0	(871)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	(59)	0	0	0	0	0	0	0	0	0	(59)	35
36	Other (specify):*	(5,000)	0	0	0	0	0	0	0	0	0	0	(5,000)	36
37	**TOTAL Ownership**	(5,892)	1,928	0	0	0	0	0	0	0	0	0	(3,964)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(7,736)	0	0	0	0	0	0	0	0	0	0	(7,736)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(980)	0	0	0	0	0	0	0	0	0	0	(980)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(8,716)	0	0	0	0	0	0	0	0	0	0	(8,716)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(48,175)	35,685	(10,454)	0	0	0	0	0	0	0	0	(22,944)	45

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ROGER RICHARD MARTIAL TRUST	22	ST. ANN'S HEALTHCARE	CHESTER	RDR MGMT	ALBERS	MGMT
BLAIN RICHARD	28	ST. ANN'S HEALTHCARE	CHESTER			
BLAIN RICHARD	25	CLINTON MANOR	NEW BADEN			
MIKE & GAIL GREER	100	O'FALLON HEALTHCARE	O'FALLON	GREER MGMT	TRENTON	MGMT
MIKE & GAIL GREER	50	ST. ANN'S HEALTHCARE	CHESTER			
MIKE & GAIL GREER	25	CLINTON MANOR	NEW BADEN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	35	COMPUTER LEASE	$ 59	RDR MGMT LEASE		$	$ (59)	1
2	V	32	INTEREST				21	21	2
3	V	30	DEPRECIATION				1,966	1,966	3
4	V	17	MANAGEMENT	36,000	RDR MGMT		32,003	(3,997)	4
5	V	21	CLERICAL				32,287	32,287	5
6	V	19	LEGAL				364	364	6
7	V	22	PAYROLL TAXES				5,103	5,103	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 36,059			$ 71,744	$ * 35,685	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT	$ 36,000	GREER MANAGEMENT		$ 11,375	$ (24,625)	15
16	V	21	CLERICAL		GREER MANAGEMENT		7,499	7,499	16
17	V	21	OFFICE SUPPLIES		GREER MANAGEMENT		3,143	3,143	17
18	V	22	PAYROLL TAXES		GREER MANAGEMENT		1,909	1,909	18
19	V	24	SEMINAR/EDUCATION		GREER MANAGEMENT		392	392	19
20	V	20	DUES/SUBSCRIPTIONS		GREER MANAGEMENT		411	411	20
21	V	19	PROFESSIONAL FEES		GREER MANAGEMENT		752	752	21
22	V	6	REPAIRS & MAINT		GREER MANAGEMENT		65	65	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 36,000			$ 25,546	$ * (10,454)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BLAIN RICHARD	SEC	WORK OFCR	28.00	ST.ANN'S	20	50.00		$		1
2	MIKE GREER	V.PRES	WORK OFCR	50.00	ST.ANN'S	8	20.00				2
3	DIXIE RICHARD	PRES	WORK OFCR	22.00	ST.ANN'S	10	25.00				3
4	MIKE GREER	PRES	O'FALLON	100.00		8	20.00				4
5	DIXIE RICHARD	MGMT CO	RDR MGMT		ST.ANN'S	20	50.00	MGMT FEES	36,000	17-3	5
6	MIKE GREER	MGMT CO	GREER MGMT		ST.ANN'S	10	25.00	MGMT FEES	36,000	17-3	6
7	MIKE GREER	MGMT CO	O'FALLON		33,020	10	25.00				7
8	MIKE GREER	GREER MGMT	CLINTON	25.00	36,000	2	5.00				8
9	DIXIE RICHARD	RDR MGMT	CLINTON		24,000	8	20.00				9
10	BLAIN RICHARD	PRES	CLINTON	25.00	12,000	20	50.00				10
11	MIKE GREER	GREER MGMT	SO. IL.COMM SP		14,223	2	5.00				11
12	DIXIE RICHARD	RDR MGMT	SO. IL.COMM SP		14,223	2	5.00				12
13								TOTAL	$ 72,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: RDR MANAGEMENT
Street Address: 5617 ALBERS ROAD
City / State / Zip Code: ALBERS,IL 62215
Phone Number: (618-248-5642
Fax Number: (618-248-5905

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	MANAGEMENT FEES	74,243	3	$ 66,000	$ 66,000	36,000	$ 32,003	1
2	21	CLERICAL	MANAGEMENT FEES	74,243	3	66,000	66,000	36,000	32,003	2
3	19	ACCOUNTING	MANAGEMENT FEES	74,243	3	660		36,000	320	3
4	19	LEGAL	MANAGEMENT FEES	74,243	3	90		36,000	44	4
5	21	OFFICE EXP	MANAGEMENT FEES	74,243	3	188		36,000	91	5
6	21	TELEPHONE	MANAGEMENT FEES	74,243	3	398		36,000	193	6
7	22	PAYROLL TAXES	MANAGEMENT FEES	74,243	3	10,524		36,000	5,103	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 143,860	$ 132,000		$ 69,757	25

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization GREER MGMT
Street Address 581 COUNTRYSIDE LANE
City / State / Zip Code TRENTON,IL 62293
Phone Number (618-224-7715
Fax Number (618-224-7716

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	MANAGEMENT FEES	119,243	4	$ 37,678	$ 37,678	36,000	$ 11,375	1
2	21	CLERICAL WAGES	MANAGEMENT FEES	119,243	4	24,839	24,839	36,000	7,499	2
3	22	PAYROLL TAXES	MANAGEMENT FEES	119,243	4	6,323		36,000	1,909	3
4	6	REPAIRS & MAINT	MANAGEMENT FEES	119,243	4	216		36,000	65	4
5	21	OFFICE EXPENSES	MANAGEMENT FEES	119,243	4	6,466		36,000	1,952	5
6	24	SEMINAR	MANAGEMENT FEES	119,243	4	1,298		36,000	392	6
7										7
8	21	TELEPHONE	MANAGEMENT FEES	119,243	4	3,945		36,000	1,191	8
9	20	DUES/SUBSCRIPTIONS	MANAGEMENT FEES	119,243	4	1,360		36,000	411	9
10	19	PROF FEES	MANAGEMENT FEES	119,243	4	2,490		36,000	752	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 84,615	$ 62,517		$ 25,546	25

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	FIRST NATL BANK		X	MORTGAGE	$9,436.74	10-03-01	$ 850,000	$ 682,962	10-15-06	4.7800	$ 30,573	1
2												2
3												3
4												4
5												5
	Working Capital											
6	OWNERS LOANS	X		CASH FLOW		04-01-03	579,000	579,000	03-31-04	6.5000	23,100	6
7	VILLAGE BANK		X	AUTO LOAN	$578.00	12-01-99	27,740	5,207	11-30-04	8.2500	672	7
8	BUENA VISTA		X	LINE OF CREDIT		01-01-03	50,000	150,000			3,142	8
9	TOTAL Facility Related				$10,014.74		$ 1,506,740	$ 1,417,169			$ 57,487	9
	B. Non-Facility Related*											
10	INTEREST ON EQUIP	X		RDR MGMT							21	10
11	INVESTMENT INT		X								(892)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (871)	14
15	TOTALS (line 9+line14)						$ 1,506,740	$ 1,417,169			$ 56,616	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER **#** 0023390 **Report Period Beginning:** 01-01-03 **Ending:** 12-31-03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	16,889	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	30,757	2
3. Under or (over) accrual (line 2 minus line 1).	$	13,868	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	16,977	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	30,845	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	27,414	8
	1999	27,526	9
	2000	29,522	10
	2001	30,471	11
	2002	30,757	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ST ANN'S HEALTHCARE CENTER COUNTY RANDOLF

FACILITY IDPH LICENSE NUMBER 0023390

CONTACT PERSON REGARDING THIS REPORT MIKE GREER

TELEPHONE 618-826-2314 FAX #: 618-826-5047

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-034-011-0	NURSING HOME	$ 29,242.20	$ 29,242.20
2.	18-040-003-0	NURSING HOME	$ 207.04	$ 207.04
3.	18-034-009-0	NURSING HOME	$ 75.44	$ 75.44
4.	18-037-006-0	NURSING HOME	$ 135.04	$ 135.04
5.	18-031-012-0	NURSING HOME	$ 1,097.14	$ 1,097.14
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 30,756.86	$ 30,756.86

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,246 B. General Construction Type: Exterior BRICK Frame WOOD.STEEL Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

RESIDENTIAL APARTMENTS 3248 SQFT 2FLOORS 4 BEDROOMS
HOUSE 2625 SQ FT 2 FLOORS 7 BEDROOMS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	103,500	1977	$ 20,000	1
2					2
3	TOTALS	103,500		$ 20,000	3

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	48		1977	1937	$ 404,102	$	20	$	$	$ 404,102	4
5	46		1977	1976	250,000	7,327	33	7,327		204,814	5
6	10		1985	1985	104,150	3,171	33	3,171		59,489	6
7	15		1987	1987	344,144	10,417	33	10,417		170,526	7
8			1991	1991	357,704	11,964	30	11,964		143,353	8
	Improvement Type**										
9	BUILDING IMP			1978	500		8			500	9
10	NEW ROOF			1983	9,450		15			9,450	10
11	BUILDING IMP			1983	4,469		15			4,469	11
12	ELECTRICAL IMP			1985	3,130		15			3,130	12
13	ROOF REPAIRS			1987	1,830	92	20	92		1,476	13
14	FIRE ALARM			1987	3,900		8			3,900	14
15	OFFICE BUILDING			1985	28,500	1,432	20	1,432		26,233	15
16	NEW ROOF			1989	4,000	270	15	270		3,798	16
17	PARKING LOT			1991	7,708		10			7,708	17
18	BUILDING IMP			1992	12,806	502	20	502		8,747	18
19	TELEPHONE SYSTEM			1992	10,071		10			10,071	19
20	CUBICLE TRACK			1992	6,531		8			6,531	20
21	LAND IMP			1993	1,897	127	15	127		1,281	21
22	A/C UNIT			1984	5,625		8			5,625	22
23	BUILDING IMP			1994	45,734	2,685	20	2,685		26,789	23
24	BUILDING IMP			1993	10,012	499	10	499		10,012	24
25	PAINTING			1995	11,460	1,190	10	1,190		10,368	25
26	ROOF REPAIRS			1995	11,167	561	20	561		4,990	26
27	HANDRAILS			1995	20,700	221	8	221		20,700	27
28	BOILER			1995	21,690	1,455	15	1,455		11,869	28
29	ELECTRIAL,FIRE ALARM			1997	12,017	1,168	8	1,168		7,570	29
30	NEW ROOF			1999	30,546	1,535	20	1,535		7,038	30
31	NEW ROOF			2000	3,990	266	15	266		865	31
32	A/C UNIT			2000	7,265	907	8	907		3,485	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,735,098	$ 45,789		$ 45,789	$	$ 1,178,889	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 204,052	$ 19,917	$ 21,883	$ 1,966	8	$ 138,218	71
72	Current Year Purchases	7,831	802	802		8	802	72
73	Fully Depreciated Assets	6,992				8	6,992	73
74								74
75	TOTALS	$ 218,875	$ 20,719	$ 22,685	$ 1,966		$ 146,012	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	85 CHEV BUS	1996	$ 6,000	$	$	$	3	$ 6,000	76
77	FACILITY	96 DODGE VAN	2001	4,463	372	372		3	372	77
78	FACILITY	VAN	2001	17,811	3,622	3,622		3	7,245	78
79								3		79
80	TOTALS			$ 28,274	$ 3,994	$ 3,994	$		$ 13,617	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,002,247	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 70,502	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 72,468	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,966	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,338,518	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	ADM AUTO	$ 27,739	$	$ 27,739	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 27,739	$	$ 27,739	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 59 Description: COMPUTER EQUIP
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts	126,905					126,905	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): PHARMACY BILLING			(7,736)					(7,736)	13
14	TOTAL			$ 119,169		$	$		$ 119,169	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 **Report Period Beginning:** 01-01-03 **Ending:** 12-31-03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12-31-03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 146,099	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (21,387))	684,966		3
4	Supply Inventory (priced at FIFO)	33,550		4
5	Short-Term Investments			5
6	Prepaid Insurance	12,954		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 877,569	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000		13
14	Buildings, at Historical Cost	1,788,048		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	277,912		16
17	Accumulated Depreciation (book methods)	(1,413,522)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 677,438	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,555,007	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 78,292	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	5,207		29
30	Accrued Salaries Payable	99,167		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,748		31
32	Accrued Real Estate Taxes(Sch.IX-B)	3,404		32
33	Accrued Interest Payable	16,166		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 208,984	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	579,000		39
40	Mortgage Payable	682,962		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	LINE OF CREDIT	150,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,411,962	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,620,946	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (65,939)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,555,007	$	48

***(See instructions.)**

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 72,379	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 72,379	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(138,727)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) RESIDENTIAL DIVISION	409	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (138,318)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (65,939)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,571,008	1
2	Discounts and Allowances for all Levels	(99,732)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,471,276	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	365,753	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 365,753	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	10,110	12
13	Barber and Beauty Care	8,095	13
14	Non-Patient Meals	5,098	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	600	16
17	Sale of Drugs	130,573	17
18	Sale of Supplies to Non-Patients	887	18
19	Laboratory	1,140	19
20	Radiology and X-Ray	404	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 156,907	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	892	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 892	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,994,828	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	695,089	31
32	Health Care	1,435,954	32
33	General Administration	616,564	33
	B. Capital Expense		
34	Ownership	163,893	34
	C. Ancillary Expense		
35	Special Cost Centers	156,902	35
36	Provider Participation Fee	65,153	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,133,555	40
41	**Income before Income Taxes (line 30 minus line 40)****	(138,727)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (138,727)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,088	2,088	$ 53,475	$ 25.61	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,598	7,134	117,810	16.51	3
4	Licensed Practical Nurses	22,930	24,943	313,366	12.56	4
5	Nurse Aides & Orderlies	49,805	51,170	463,602	9.06	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,339	5,094	51,019	10.02	8
9	Activity Director	1,936	2,429	20,996	8.64	9
10	Activity Assistants	1,677	1,850	13,801	7.46	10
11	Social Service Workers	3,294	3,422	33,982	9.93	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	4,056	4,168	50,477	12.11	15
16	Dishwashers	18,444	19,283	130,572	6.77	16
17	Maintenance Workers	3,564	3,836	37,657	9.82	17
18	Housekeepers	8,170	8,930	71,311	7.99	18
19	Laundry	6,904	7,320	53,438	7.30	19
20	Administrator	2,088	2,088	63,076	30.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,513	8,265	90,112	10.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	143,406	152,020	$ 1,564,694 *	$ 10.29	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 5,064	1-3	35
36	Medical Director				36
37	Medical Records Consultant	24	4,720	10-3	37
38	Nurse Consultant	96	4,325	10-3	38
39	Pharmacist Consultant	96	2,525	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,378	11-3	44
45	Social Service Consultant	96	7,188	12-3	45
46	Other(specify) RELIGIOUS		1,800	11-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	456	$ 28,000		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TOM SELDERS	ADM		$ 63,076
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 63,076

B. Administrative - Other

Description	Amount
RDR MANAGEMENT	$ 36,000
GREER MANAGEMENT	36,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 72,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
HERMAN BODEWES	LEGAL	$ 2,167
WDM COMPUTER	ACCOUNTING	18,168
VAN OSTRAND	CONSULTING	602
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 20,937

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,511
Unemployment Compensation Insurance	15,397
FICA Taxes	116,009
Employee Health Insurance	21,831
Employee Meals	4,377
Illinois Municipal Retirement Fund (IMRF)*	
401K PLAN	500
TOTAL (agree to Schedule V, line 22, col.8)	$ 200,625

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,190
Advertising: Employee Recruitment	1,471
Health Care Worker Background Check	
(Indicate # of checks performed 45)	540
DUES &SUBSCRIPTION	1,511
ILL HEALTHCARE ASSON	6,998
ILL DEPT OF PROF REG	200
ILL SEC OF STATE	531
NON ALLOW	(571)
ADVERTISING	24,596
Less: Public Relations Expense	( )
Non-allowable advertising	(24,596)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,870

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
	7,774
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,774

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER # 0023390 Report Period Beginning: 01-01-03 Ending: 12-31-03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ST ANN'S HEALTHCARE CENTER **#** 0023390 **Report Period Beginning:** 01-01-03 **Ending:** 12-31-03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILLINOIS HAELTHCARE**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **571**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **8**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,371** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,153**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **4,377** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **5,098**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **50**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? N
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **N**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.